Total laparoscopic hysterectomy in a woman with uterine didelphys, longitudinal vaginal septum and grade IV endometriosis: A case report

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Background

Congenital malformations of the genital tract occur in 4-7% of women[1]. Uterine didelphys and a longitudinal vaginal septum occur with complete lack of fusion of the Mullerian ducts during embryological development (Fig. 1). Endometriosis is present in up to 10% of women and can cause distortion of anatomy[2]. Aberrations in normal anatomy, whether congenital or acquired, can pose significant challenges to surgeons.

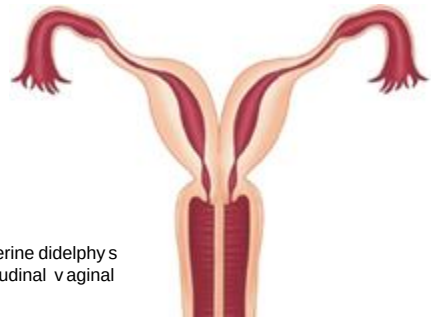

Fig. 1. Uterine didelphys with longitudinal vaginal septum

Case

A 33-year old nulligravida women with known grade IV endometriosis, uterine didelphys, longitudinal vaginal septum and infertility presented to her gynaecologist requesting hysterectomy. Previous management included two laparoscopic resections of endometriosis, and hormonal therapy with a progestin and GnRH agonist. She was trying to conceive for 2 years and had one unsuccessful cycle of IVF. Her pain was chronic and debilitating. Pre-operative investigations included normal bloods, and a deep infiltrative endometriosis US revealed an obliterated Pouch of Douglas and rectal nodule with possible mucosal involvement. MRI detailed the Mullerian anomaly and she had a normal renal tract. A colorectal (CR) surgeon was consulted to review the woman, discuss surgery and consent her for possible bowel resection, and attend the surgery.

Procedure

- Longitudinal vaginal septum resected to allow vaginal removal of the hysterectomy specimen
- At laparoscopy, significant adhesiolysis and bowel resection by CR surgeons
- Bilateral ureterolysis and resection of grade IV endometriosis
- Total laparoscopic hysterectomy with Harmonic scalpel
- Inadvertent bladder injury repaired in 2 layers
- Normal cystoscopy
- Intra-abdominal drain, vagina packed

Post-operatively, the woman developed a UTI on day 5, but recovery was otherwise unremarkable.

Discussion

Thorough pre-operative work-up, multi-disciplinary input and surgical planning ensure optimal preparation for procedures. This case represents a RANZCOG/AGES level 6 endoscopic procedure, and one in which these elements were paramount for optimising patient outcomes.

References
1 Dietrich JE, Millar DM, Quint EH. Non-obstructive Müllerian Anomalies. Journal of Pediatric and Adolescent Gynecology. 2014;27:386-95
2 Dunselman GA, Vermeulen N, Becker C, Calhaz-Jorge C, D'Hooghe T, De Bie B, Heikinheimo O, Horne AW, Kiesel L, Nap A, Prentice A, Saridogan E, Soriano D, Nelen W. ESHRE guideline: management of women with endometriosis. Hum Reprod. 2014 Mar;29(3):400-12.